STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011772	A. BUILDING: _____ B. WING _____	02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEART HOSPITAL AT DEACONESS GATEWAY LI	4007 GATEWAY BLVD NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Reviewer/ Surveyor: Nancy Otten, RN, PHNS Surveyor #: 33212 Facility # 011772 Type of Survey: State Licensure Off-site HFAP Accreditation Survey Date of HFAP On-site survey: 02/20/2012-02/21/2012 Date of ISDH Off-site review: 09/05/2013 Based on review of the 2/20-21/2012 On-site HFAP Survey Report, it has been determined that The Heart Hospital at Deaconess Gateway meets the requirements for Indiana State Hospital Licensure in 2012.	S 000		